

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045633</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Aledo Health and Rehabilitation Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>304 S.W. 12th Street</u> <u>Aledo</u> <u>61231</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Mercer</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(309) 582-5376</u> Fax # <u>(309) 582-2435</u>		(Type or Print Name) _____	
IDPA ID Number: <u>371416417002</u>		(Title) _____	
Date of Initial License for Current Owners: <u>01/18/02</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aledo Health and Rehabilitation Center# 0045633 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 5/19/2002

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>100</u>	Skilled (SNF)	<u>90</u>	<u>34,230</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>90</u>	<u>34,230</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,063</u>	<u>6,573</u>	<u>1,188</u>	<u>23,824</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,063</u>	<u>6,573</u>	<u>1,188</u>	<u>23,824</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.60%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/18/02

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 01/01/2002NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 12 and days of care provided 1,188Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Aledo Health and Rehabilitation Center # 0045633 Report Period Beginning: 01/01/02 Ending: 12/31/02**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	109,826	10,387	4,845	125,058		125,058		125,058		1
2	Food Purchase		112,202		112,202		112,202	(2,183)	110,019		2
3	Housekeeping	55,665	7,333		62,998		62,998		62,998		3
4	Laundry	25,923	5,150		31,073		31,073		31,073		4
5	Heat and Other Utilities			80,488	80,488		80,488		80,488		5
6	Maintenance	16,182		25,266	41,448		41,448		41,448		6
7	Other (specify):*										7
8	TOTAL General Services	207,596	135,072	110,599	453,267		453,267	(2,183)	451,084		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	918,412	24,043	665	943,120		943,120		943,120		10
10a	Therapy		39	114,394	114,433		114,433		114,433		10a
11	Activities	31,294		3,184	34,478		34,478		34,478		11
12	Social Services			2,248	2,248		2,248		2,248		12
13	Nurse Aide Training			1,581	1,581		1,581		1,581		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	949,706	24,082	128,072	1,101,860		1,101,860		1,101,860		16
	C. General Administration										
17	Administrative	59,413			59,413		59,413		59,413		17
18	Directors Fees										18
19	Professional Services			54,715	54,715		54,715		54,715		19
20	Dues, Fees, Subscriptions & Promotions			8,298	8,298		8,298	(336)	7,962		20
21	Clerical & General Office Expenses	14,345	7,137	9,872	31,354		31,354		31,354		21
22	Employee Benefits & Payroll Taxes			189,882	189,882		189,882		189,882		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,643	3,643		3,643	(1,455)	2,188		24
25	Other Admin. Staff Transportation			1,029	1,029		1,029		1,029		25
26	Insurance-Prop.Liab.Malpractice			51,952	51,952		51,952		51,952		26
27	Other (specify):*										27
28	TOTAL General Administration	73,758	7,137	319,391	400,286		400,286	(1,791)	398,495		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,231,060	166,291	558,062	1,955,413		1,955,413	(3,974)	1,951,439		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,714	21,714		21,714		21,714			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,310	102,310		102,310		102,310			32
33	Real Estate Taxes			16,200	16,200		16,200		16,200			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,469	1,469		1,469		1,469			35
36	Other (specify):*											36
37	TOTAL Ownership			141,693	141,693		141,693		141,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,935	6,692	43,627		43,627		43,627			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,570	51,570		51,570		51,570			42
43	Other (specify):* Nonallowable Costs			16,829	16,829		16,829	(16,829)				43
44	TOTAL Special Cost Centers		36,935	75,091	112,026		112,026	(16,829)	95,197			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,231,060	203,226	774,846	2,209,132		2,209,132	(20,803)	2,188,329			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Aledo Health and Rehabilitation Center# 0045633Report Period Beginning: 01/01/02Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(2,183)	2		4
5 Telephone, TV & Radio in Resident Rooms	(6,150)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(336)	20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(10,000)	43		24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(679)	43		28
29 Other-Attach Schedule Non-Allowable Travel	(1,455)	24		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,803)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (20,803)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
Aledo Health and Rehabilitation Center

Page 5A

ID# 0045633
Report Period Beginning: 01/01/02
Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountant's Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aledo Health and Rehabilitation Center# 0045633

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,183)	0	0	0	0	0	0	0	0	0	0	(2,183)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,183)	0	0	0	0	0	0	0	0	0	0	(2,183)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(336)	0	0	0	0	0	0	0	0	0	0	(336)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(336)	0	0	0	0	0	0	0	0	0	0	(336)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,519)	0	0	0	0	0	0	0	0	0	0	(2,519)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Aledo Health and Rehabilitation Center# 0045633

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robertson Health Care, LLC	100%	Effingham Health and Rehabilitation Center	Effingham			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V		N/A						3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aledo Health and Rehabilitation Center # 0045633 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lester Robertson	Executive VP	Administrative	100.00	81,250	10	26.00	Salary	\$ 0	L17, C1	1
2											2
3											3
4											4
5					* All compensation received from Effingham Health and Rehabilitation Center						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aledo Health and Rehabilitation Center # 0045633 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Carol Fleming		X	Mortgage	\$12,423.00	02/01/02	\$ 1,300,000	\$ 1,257,270	02/01/17	0.0800	\$ 102,310	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$12,423.00		\$ 1,300,000	\$ 1,257,270			\$ 102,310	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,300,000	\$ 1,257,270			\$ 102,310	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aledo Health and Rehabilitation Cente COUNTY Mercer

FACILITY IDPH LICENSE NUMBER 0045633

CONTACT PERSON REGARDING THIS REPORT Lester Robertson

TELEPHONE (309) 582-5376 FAX #: (309) 582-2435

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>10-10-20-302-002</u>	<u>Nursing Facility</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
2.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
3.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
4.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
5.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
6.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
7.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
8.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
9.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
10.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

See Accountants' Compilation Report

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

27,378

B. General Construction Type:

Exterior

Brick

Frame

Block

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	103,498	2002	\$ 40,750	1
2					2
3	TOTALS	103,498		\$ 40,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	100		2002	1973	\$ 1,112,250	\$ 13,903	40	\$ 13,903	\$	\$ 13,903	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,112,250	\$ 13,903		\$ 13,903	\$	\$ 13,903	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	146,222	7,311	7,311		10	7,311	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 146,222	\$ 7,311	\$ 7,311	\$		\$ 7,311	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Van	2002	\$ 5,000	\$ 500	\$ 500		10	\$ 500	76
77										77
78										78
79										79
80	TOTALS			\$ 5,000	\$ 500	\$ 500			\$ 500	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,304,222	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,714	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,714	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,714	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,469 Description: Dishwasher - \$180; Copier - \$1,289

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,288	\$	\$ 1,288
2	Books and Supplies		293		293
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,581	\$	\$ 1,581
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,581		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	L10a, C3	hrs	\$	1,079	\$ 48,535	\$	1,079	\$ 48,535	1					
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		189	11,327		189	11,327	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	L10a, C3, C2	hrs		1,204	54,196	39	1,204	54,235	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy	L39, C2	# of prescripts				36,935		36,935	9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Exceptional Care Program									12					
13	Other (specify): Laboratory	L39, C3				6,692			6,692	13					
14	TOTAL			\$	2,472	\$ 120,750	\$ 36,974	2,472	\$ 157,724	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 80,962	\$ 80,962	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	311,620	311,620	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,203	18,203	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 410,785	\$ 410,785	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,750	40,750	13
14	Buildings, at Historical Cost	1,112,250	1,112,250	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	151,222	151,222	16
17	Accumulated Depreciation (book methods)	(21,714)	(21,714)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	21,193	21,193	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,303,701	\$ 1,303,701	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,714,486	\$ 1,714,486	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 60,385	\$ 60,385	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,319	50,319	29
30	Accrued Salaries Payable	64,206	64,206	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,200	16,200	32
33	Accrued Interest Payable	8,382	8,382	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	226,551	226,551	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 426,043	\$ 426,043	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,206,951	1,206,951	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,206,951	\$ 1,206,951	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,632,994	\$ 1,632,994	46
47	TOTAL EQUITY (page 18, line 24)	\$ 81,492	\$ 81,492	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,714,486	\$ 1,714,486	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number: Aledo Health and Rehabilitation Center
Provider # 0045633
12/31/2002

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

B. Long-Term Assets

Other (specify):	Operating	After Consolidation
Real Estate Tax Escrow	17,600	17,600
Deposit	3,593	3,593
Total Line 23 - Other(specify):	21,193	21,193

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Due to Related Parties	158,594	158,594
Due to Resident Trust Fund	215	215
Accrued Legal and Accounting	40,775	40,775
Accrued Assessment Fees	27,600	27,600
Wage Assignment Payable	(698)	(698)
Credit Union Payable	65	65
Total Line 36 - Other Current Liabilities(specify):	226,551	226,551

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	81,492	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 81,492	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 81,492	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Aledo Health and Rehabilitation Center

0045633

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,141,759	1
2	Discounts and Allowances for all Levels	(168,958)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,972,801	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,238	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 234,238	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,183	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,864	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,164	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,319	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,530	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	19,055	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,055	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,290,624	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	453,267	31
32	Health Care	1,101,860	32
33	General Administration	400,286	33
B. Capital Expense			
34	Ownership	141,693	34
C. Ancillary Expense			
35	Special Cost Centers	60,456	35
36	Provider Participation Fee	51,570	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,209,132	40
41	Income before Income Taxes (line 30 minus line 40)**	81,492	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 81,492	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files as a part of a combined cash basis return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number: Aledo Health and Rehabilitation Center
Provider # 0045633
12/31/2002

Schedule 19A

XVII. Income Statement
E. Other Revenues

Other (specify):	Operating
Vending Income	1,081
Respite and Day Care Income	3,015
CNA Training Reimbursement	1,581
Bedhold Income	8,856
Cable TV Income	4,522
Total Line 23 - Other(specify):	19,055

See Accountants' Compilation Report

Facility Name & ID Number **Aledo Health and Rehabilitation Center**# **0045633**Report Period Beginning: **01/01/02**Ending: **12/31/02**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,847	1,855	\$ 39,582	\$ 21.34	1
2	Assistant Director of Nursing	1,739	1,755	29,148	16.61	2
3	Registered Nurses	4,136	4,259	91,465	21.48	3
4	Licensed Practical Nurses	11,665	11,804	173,850	14.73	4
5	Nurse Aides & Orderlies	72,118	73,937	555,651	7.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,575	1,635	11,734	7.18	8
9	Activity Director	1,802	1,818	14,332	7.88	9
10	Activity Assistants	2,642	2,711	16,962	6.26	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,857	1,870	15,674	8.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,311	6,579	51,809	7.87	15
16	Dishwashers	6,934	7,047	42,343	6.01	16
17	Maintenance Workers	1,997	1,997	16,182	8.10	17
18	Housekeepers	8,355	8,477	55,665	6.57	18
19	Laundry	4,041	4,044	25,923	6.41	19
20	Administrator	1,993	1,993	59,413	29.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,649	1,666	14,345	8.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,877	1,905	16,982	8.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,538	135,352	\$ 1,231,060 *	\$ 9.10	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	653	\$ 4,845	L1, C3	35
36	Medical Director	96	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	665	L10, C3	39
40	Physical Therapy Consultant	9	136	L10a, C3	40
41	Occupational Therapy Consultant	13	200	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	313	2,248	L11, C3	44
45	Social Service Consultant	313	2,248	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,397	\$ 16,342		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	% Ownership	Amount	Description	Amount
Jimmie Steenbergren	Administrator	0%	\$ 59,413	Workers' Compensation Insurance	\$ 40,922
				Unemployment Compensation Insurance	26,806
				FICA Taxes	89,544
				Employee Health Insurance	29,017
				Employee Meals	
				Illinois Municipal Retirement Fund (IMRF)*	
				Other Employee Benefits	3,593
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 59,413		
(List each licensed administrator separately.)					
B. Administrative - Other					
Description			Amount		
N/A			\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$		
(Attach a copy of any management service agreement)					
C. Professional Services					
Vendor/Payee	Type		Amount	Description	Line # Amount
American Express Tax & Business Services, Inc.	Accounting		\$ 47,186	N/A	
Altschuler, Melvoin & Glasser LLP	Accounting		4,483		
ADP	Payroll Service		3,046		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 54,715	TOTAL	\$
(If total legal fees exceed \$2500 attach copy of invoices.)					
D. Employee Benefits and Payroll Taxes					
Description	Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
IDPH License Fee	\$ 150	Description	Line #	Amount	
Advertising: Employee Recruitment	906				
Health Care Worker Background Check (Indicate # of checks performed 16)	196				
Illinois Health Care Association	5,225				
Chamber of Commerce	100				
Mercer County Health Licensure	200				
IHFPB Change of Owner Fee	1,000				
Illinois Secretary of State	10				
Miscellaneous Licenses	175				
Less: Public Relations Expense	(
Non-allowable advertising	(
Yellow page advertising	(
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,962	TOTAL (agree to Schedule V, line 22, col.8)	\$ 189,882		
G. Schedule of Travel and Seminar**					
Description	Amount				
Out-of-State Travel	\$				
In-State Travel	998				
Seminar Expense	1,190				
Entertainment Expense	(	(agree to Sch. V,			
		TOTAL (agree to Sch. V, line 24, col. 8) \$ 2,188			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

Amount of Expense Amortized Per Year													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Aledo Health and Rehabilitation Center**

STATE OF ILLINOIS

0045633

Report Period Beginning:

01/01/02

Ending:

Page 23

12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$5,225
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 304 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
Lynncrest Manor of Aledo IDPH # 0041467; Acquired 01/01/2002
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,570
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,183
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 10%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Aledo Health and Rehabi

02:03 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-20,803	equal to	-20,803	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	102,310	equal to	102,310	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	16,200	equal to	16,200	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	21,714	equal to	21,714	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,469	equal to	1,469	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	1,581	equal to	1,581	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	114,433	equal to	114,433	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	36,974	equal to	36,974	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	453,267	equal to	453,267	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,101,860	equal to	1,101,860	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	400,286	equal to	400,286	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	141,693	equal to	141,693	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	60,456	equal to	60,456	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	51,570	equal to	51,570	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	906,678	equal to	918,412	-11,734	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	31,294	equal to	31,294	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to	0	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	109,826	equal to	109,826	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	16,182	equal to	16,182	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	55,665	equal to	55,665	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	25,923	equal to	25,923	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	59,413	equal to	59,413	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,345	equal to	14,345	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,231,060	equal to	1,231,060	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,845	< or = to	4,845	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	665	< or = to	665	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,248	< or = to	3,184	-936	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,248	< or = to	2,248	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	59,413	equal to	59,413	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	54,715	equal to	54,715	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	189,882	equal to	189,882	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,962	equal to	7,962	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,188	equal to	2,188	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	51,570	equal to	51,570	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,188	equal to	1,188	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	1,257,270	equal to	1,257,270	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	16,200	equal to	16,200	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	40,750	equal to	40,750	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,112,250	equal to	1,112,250	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	151,222	equal to	151,222	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	21,714	equal to	21,714	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	81,492	equal to	81,492	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	81,492	equal to	81,492	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,714,486	equal to	1,714,486	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	109,826	10,387	4,845	125,058	0	125,058	0	125,058
2. Food P	0	112,202	0	112,202	0	112,202	-2,183	110,019
3. Housek	55,665	7,333	0	62,998	0	62,998	0	62,998
4. Laundry	25,923	5,150	0	31,073	0	31,073	0	31,073
5. Heat ar	0	0	80,488	80,488	0	80,488	0	80,488
6. Mainte	16,182	0	25,266	41,448	0	41,448	0	41,448
7. Other (	0	0	0	0	0	0	0	0
8. Total G	207,596	135,072	110,599	453,267	0	453,267	-2,183	451,084
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	918,412	24,043	665	943,120	0	943,120	0	943,120
10a. Ther	0	39	114,394	114,433	0	114,433	0	114,433
11. Activi	31,294	0	3,184	34,478	0	34,478	0	34,478
12. Social	0	0	2,248	2,248	0	2,248	0	2,248
13. Nurse	0	0	1,581	1,581	0	1,581	0	1,581
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	949,706	24,082	128,072	1,101,860	0	1,101,860	0	1,101,860
17. Admin	59,413	0	0	59,413	0	59,413	0	59,413
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	54,715	54,715	0	54,715	0	54,715
20. Fees,	0	0	8,298	8,298	0	8,298	-336	7,962
21. Cleric	14,345	7,137	9,872	31,354	0	31,354	0	31,354
22. Emplo	0	0	189,882	189,882	0	189,882	0	189,882
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	3,643	3,643	0	3,643	-1,455	2,188
25. Other	0	0	1,029	1,029	0	1,029	0	1,029
26. Insura	0	0	51,952	51,952	0	51,952	0	51,952
27. Other	0	0	0	0	0	0	0	0
28. Total I	73,758	7,137	319,391	400,286	0	400,286	-1,791	398,495
29. Total J	1,231,060	166,291	558,062	1,955,413	0	1,955,413	-3,974	1,951,439
30. Depre	0	0	21,714	21,714	0	21,714	0	21,714
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	102,310	102,310	0	102,310	0	102,310
33. Real E	0	0	16,200	16,200	0	16,200	0	16,200
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	1,469	1,469	0	1,469	0	1,469
36. Other	0	0	0	0	0	0	0	0
37. Total K	0	0	141,693	141,693	0	141,693	0	141,693
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	36,935	6,692	43,627	0	43,627	0	43,627
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	51,570	51,570	0	51,570	0	51,570
43. Other	0	0	16,829	16,829	0	16,829	-16,829	0
44. Total L	0	36,935	75,091	112,026	0	112,026	-16,829	95,197
45. Grand	1,231,060	203,226	774,846	2,209,132	0	2,209,132	-20,803	2,188,329

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on	80,962	80,962
2. Cash - F	0	0
3. Account	311,620	311,620
4. Supply I	0	0
5. Short-T	0	0
6. Prepaid	18,203	18,203
7. Other Pi	0	0
8. Account	0	0
9. Other (s	0	0
10. Total c	410,785	410,785
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	40,750	40,750
14. Buildin	1,112,250	1,112,250
15. Lease	0	0
16. Equipn	151,222	151,222
17. Accum	-21,714	-21,714
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	0
23. other (:	21,193	21,193
24. Total L	1,303,701	1,303,701
25. Total A	1,714,486	1,714,486
CURRENT LIABILITIES		
26. Accour	60,385	60,385
27. Officer	0	0
28. Accour	0	0
29. Short-T	50,319	50,319
30. Accrue	64,206	64,206
31. Accrue	0	0
32. Accrue	16,200	16,200
33. Accrue	8,382	8,382
34. Deferre	0	0
35. Federa	0	0
36. Other (	226,551	226,551
37. Other (	0	0
38. Total C	426,043	426,043
LONG TERM LIABILITIES		
39. Long-T	1,206,951	1,206,951
40. Mortga	0	0
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L:	1,206,951	1,206,951
46. Total Li	1,632,994	1,632,994
47. Total Ei	81,492	81,492
48. Total Li	1,714,486	1,714,486

Balance per
Medicaid
Trial Balance

1. Gross F 2,141,759
2. Discour -168,958

Subtota 1,972,801
4. Day Ca 0
5. Other C 0
6. Therapy 234,238
7. Oxygen 0

Subtota 234,238
9. Paymer 0
10. Other 0
11. Nurse 0
12. Gift an 0
13. Barber 0
14. Non-P 2,183
15. Teleph 0
16. Rental 0
17. Sale o 46,864
18. Sale o 0
19. Labor 10,164
20. Radiol 0
21. Other 5,319
22. Laund 0

Subtot 64,530
24. Contril 0
25. Interest 0

Subtot -
27. Other 19,055
28. Other 0
Subtot 19,055
30. Total F 2,290,624
31. Gener 680,120
32. Health 1,154,988
33. Gener 668,561
34. Owner 144,710
35. Specie 60,174
35. Provid 41,063
37. Other 0
40. Total F 2,749,616
41. Incom -458,992
42. Incom 0
43. Net In -458,992

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9 Line 16 for mortgage insurance.

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